

Maylee

RECL 11321  
Child Development Section  
Department of Pediatrics

report of the

# RESIDENTIAL CARE STUDY

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department of public welfare state of minnesota

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RESIDENTIAL CARE STUDY ADVISORY  
COUNCIL REPORT TO  
COMMISSIONER, DEPARTMENT OF  
PUBLIC WELFARE OCTOBER, 1978

INTRODUCTION:

This report summarizes the deliberations of the Residential Care Study Advisory Council and presents the members' recommendations to the Commissioner of Public Welfare.

In August, 1978, the Commissioner of Public Welfare appointed a fifteen-member advisory council to the Residential Care Study which had been initiated by the Department in September, 1977. Four members from each of the standing councils in mental health, mental retardation and chemical dependency and two alternates, one in the chemical dependency field and another in the mental retardation field, were selected by the Commissioner to serve on the Residential Care Study Advisory Council. The following charge was given to the Council:

*To make recommendations to the Commissioner of Public Welfare with respect to the future role of state-operated facilities in the residential care system for mentally ill, mentally retarded and chemically dependent persons.*

DUTIES:

1. *To review and comment on the draft statements on the future role of state hospitals compiled by the Mental Health, Mental Retardation and Chemical Dependency Divisions.*
2. *To recommend changes (additions and deletions) in those statements in order to develop explicit admission and discharge criteria in state hospitals for the three disability groups.*
3. *To examine the different specialized programs which are provided or which may be provided at state hospitals in order to develop policy recommendations to guide decisions concerning the choice of the most appropriate provider.*

**4. *To review and make policy recommendations concerning other major problems affecting state hospitals and to discuss policy recommendations to deal with them.***

Ten meetings were held from August 3 to October 10, 1978. For the majority of the meetings the group acted as a whole. During the last meeting, three subcommittees representing mental health, mental retardation and chemical dependency developed final policy recommendations for their respective disability groups.

A partial list of the topics reviewed and discussed by the Advisory Council includes:

1. Characteristics of residents currently served by state hospitals and state-operated nursing homes.
2. Characteristics of residents served by community programs.
3. Programmatic and non-programmatic reasons for the continued existence of state-operated facilities.
4. Funding inequities and their effect on client placement.
5. Regionalization and the availability of treatment resources in different areas of the state and their impact on the future role of the state facilities.
6. Policy options available for planning.
7. Advocate and consumer concerns.
8. Specialized community and state hospital programs.

SCOPE OF THE ADVISORY COUNCIL'S RECOMMENDATION:

After several meetings it became apparent that the Advisory Council probably could not, within the time allotted, make detailed recommendations concerning the types of residents to be served by state hospitals and state-operated nursing homes and the specialized programming to be provided at these state facilities. The members, then, concentrated on an examination of the draft role statements previously developed by the Department of Public Welfare's program divisions in collaboration with state hospital and community groups. The policy recommendations that follow were developed using those draft statements as a base.

## RECOMMENDATIONS

### ROLE OF THE MINNESOTA STATE HOSPITALS FOR THE MENTALLY RETARDED:

The future role of the state hospitals for the mentally retarded should be to serve the most severely retarded, and multiply handicapped population, or those with behavior problems which prevent successful community care. Service to these populations involves specially trained staff to provide medical care to sustain life, to prevent further disability, and to prepare for successful community placement.

The role and function proposal developed by the Department of Public Welfare Mental Retardation Division and attached as Appendix A of this report is accepted by the Advisory Council members as an appropriate role for state-operated facilities in the next five years. A position paper prepared by Ms. Robin Reich, an Advisory Council member, and included as Appendix B is adopted by the Advisory Council members as a general framework (1) to administratively achieve the balance between state hospitals and community-based services and (2) to provide information needed for modifying state hospital roles in the future.

Certain non-programmatic factors are also seen by the Advisory Council as very important determinants of the future role of state hospitals. Political, economic, social, and administrative factors having an impact on the state hospital functioning were presented by Advisory Council members representing the Mental Retardation field. Their concerns are presented in Appendix C of this report.

The projected state hospital population can be reduced within the next five years in accordance with the proposed role and function policy provided that: (1) resources for the development of community residential and support services continue to be available, (2) state hospital staff is given more flexibility to participate in direct care of discharged residents and to help train community health workers, (3) technical assistance is provided by the state to counties, area boards, and private providers to assure coordination in the implementation, and (4) financial incentives are given to the counties to develop the support services, such as day activity centers, necessary to maintain mentally retarded persons in the community.

Within the framework identified above, the Residential Care Study Advisory Council recommends:

- A. Adoption of the draft Role and Function statement included in Appendix A of this report.
- B. Adoption of the framework included in Appendix B of this report as a guide to study and to manage the service system.
- C. Adoption of a policy to reduce the mentally retarded population in state hospitals by (1) concentrating on accelerating the discharge from state hospitals of severely or profoundly

retarded, fully-mobile/fully-ambulant residents who present no behavior problems, (2) preventing admission to the state hospitals of those persons described in # 1, and (3) increasing the community's capability to handle behavior problems. It is estimated that the mentally retarded average population in state hospitals can be reduced up to 30% in the next five years by implementing this policy.

- D. Adoption of a policy to target funds to develop services for semi-independent living and other support services needed to attain independence.
- E. Recognition by the Department of Public Welfare of the political, economic, social and administrative factors which tend to support the continued existence of state hospitals so that these factors can be properly addressed in future planning.



RECOMMENDATION

ROLE OF THE MINNESOTA STATE HOSPITALS FOR THE MENTALLY ILL:

The role of the state hospitals for the mentally ill should be defined in conjunction with the provision of community alternatives to hospitalization in state or local hospitals. In some cases, part of the role of the state hospital should be to provide those alternatives. In any case, state hospital services for the mentally ill must not be decreased until those alternative services can be provided. Major emphasis should be placed in developing alternatives to reduce the number of mentally ill admissions to state hospitals as a means to reduce the average daily mentally ill population. This approach is bound to have a greater effect on reduction of the average daily population than the concentration on accelerating discharges would have, since the average length of stay at state hospitals is already relatively low (less than 5 months). The rationale for recommending this approach is that if more people are prevented from going into the hospital in the first place, the need for an expensive aftercare system to take care of the discharges would be minimized. This emphasis, however, should not be interpreted as meaning that an aftercare system is not necessary. There will always be discharges from state and local hospitals who will need aftercare services if they are going to make a successful adjustment. This approach does try to shift the focus of the treatment system away from the more restrictive care in hospitals toward less restrictive alternatives.

Inequities and shortcomings in the funding and placement mechanisms and lack of coordination among the different service providers are the most serious barriers to the development of comprehensive services for the mentally ill<sup>1</sup>. Changes in the state hospital programs for the mentally ill must take those barriers into consideration and must be complementary to other policies that insure that:

1. There are appropriate outpatient and inpatient services available in the community and accessible to persons with different levels of need in all areas of the state;
2. There are referral and placement mechanisms which protect the client's right to treatment in the least restrictive environment;
3. There are mechanisms to identify mental health service needs; and
4. There are stable funding mechanisms for the different levels of care in the continuum.

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1. See Appendix D of this report for a position statement submitted by the Mental Health Advocates Coalition.

Within the framework identified above, the Residential Care Study Advisory Council recommends that the draft statement on the future role of state hospitals for the mentally ill as developed by the state hospital and mental health center program directors be changed as follows<sup>2</sup>.

- A. To provide appropriate diagnostic and evaluative services for those believed to be mentally ill, when those persons are judged to be dangerous to self or others, incompetent to care for themselves during the assessment period, and/or when there is a need for extended inpatient observation. These services may be provided to self-referred persons, to those recommended by other agencies, and to those sent by courts.
- B. To provide a comprehensive range of treatment to all mentally ill who require continuous, intensive, specialized or segregated care on a residential setting including:
  - Emergency, when there are no other local resources.
  - Short-term care (one to 90 days), when there are no other resources.
  - Long-term (more than 90 days), when community residences are not available or have proved ineffective.

The regional state hospital should promote and actively participate in the development of a comprehensive continuum of care for the area. More flexible use of state hospital employees and state hospital programs to provide needed community services should be allowed. Such services may include outreach, follow-up, outpatient clinics, and others depending on the area needs. Priority should be given to the development of outpatient and residential services that would prevent the need for hospitalization or that would reduce the length-of-stay at community and state hospitals.

- C. To provide detention and treatment for those mentally ill who are judged to be a hazard to themselves or others and, therefore, in need of segregation, protection and, where required, involuntary therapies. Special attention should continue to be paid to protecting the rights of these persons.
- D. To provide in one or more hospitals specialized programs for children and adolescents needing a secure setting for treatment. The charge to the counties for these programs should reflect as much as possible the actual cost of the program. Protection of the childrens' and adolescents' rights through outside reviews and advocacy services must be an integral

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2. The original draft statement prepared by the groups is included In Appendix E.

part of the programs. Under no circumstances should children and adolescents be placed in adult units.

- E. To provide several small units throughout the state hospital system to care for geriatric mentally ill persons who cannot be treated in community facilities and who do not require extensive nursing care. As much as possible, the geriatric residents should be integrated with younger age groups within the campus.
- F. To provide a base for partial hospitalization of those mentally ill persons who need only the daytime (or night time or weekend) services of the hospital or who need only intermittent care, which is not otherwise available in the area, and provided that the service as rendered by the state hospital is part of a comprehensive mental health plan for the area.
- G. To provide a service for those mentally ill who have additional handicaps (chemical dependency, mental retardation, physical disorders) which make other forms of care ineffective or unavailable.
- H. To provide follow up services in conjunction with local community agencies and services, particularly outpatient care of a clinical nature where no other resource exists or, in certain cases, when continuity of care by hospital staff is deemed best for the client. All follow-up of individualized planning must be a three-part joint planning process between state hospitals, mental health centers, and county welfare departments. State hospital employees should be allowed enough flexibility so that they can actively participate in or directly provide the services required by the individualized plan when necessary.
- I. To provide outpatient consultation capability for the mentally ill as a back up for community mental health centers or local health professionals, particularly with respect to former state hospital patients or potential admissions.
  - a. To develop and maintain a standing policy of effective working relationships with mental health centers, county welfare departments, local hospitals, physicians, nursing homes, law enforcement, and vocational rehabilitation offices.
  - b. To establish contact with other agencies such as schools, nurses, employers, churches, charities, workshops, group homes and others as required with respect to particular patients.

- J. To assure availability of necessary psychiatric inpatient care for any resident of the receiving district, irrespective of Insurance or other personal financial resources.
- K. To devise educational and collaborative contact with families of hospitalized persons, particularly where it is clear that the onset or aggravation of the patient's illness is related to family behavior or where family support in a difficult post-hospital situation may be needed to avoid relapse. Definitive family therapy may be recommended by hospital staff, but may not necessarily be provided by them. Rather, such need may be referred to a community resource.
- L. To provide in one (or more) hospital (s) capabilities to conduct research in different areas of mental health programming and administration. The results of the research and training on its content must be shared with other components of the continuum of care whether private or public.

RECOMMENDATION

ROLE OF THE MINNESOTA STATE HOSPITALS FOR THE CHEMICALLY DEPENDENT:

To determine the specific role of each state hospital with respect to providing chemical dependency services, it is necessary to assess the needs and services of each state hospital chemical dependency receiving district and mental health program area (s). It is the position of the Residential Care Study Advisory Council that this determination can only be made by a coordinated body made up of representatives from the regional state hospital, the mental health center (s) in the state hospital receiving district, the county welfare departments in the district, lay persons, and private sector providers from the area. Therefore, the recommendations that follow represent general guidelines for state involvement in providing direct chemical dependency services<sup>3</sup>.

The Residential Care Study Advisory Council recommends:

- A. Chemical dependency units in state hospitals should be maintained because:
  - a. The state has legal obligations to provide treatment to persons referred by the courts and to persons for whom there are no other available resources.
  - b. The state hospital programs are a necessary part of the continuum of care.
  - c. The state hospitals may be the only available resource in some of the rural areas of the state.
- B. The state hospitals, like any private treatment facility, should conform to Joint Commission on Accreditation of Hospitals standards.
- C. The quality of the state hospitals' chemical dependency programs should be comparable to that of private facilities. The quality of the state hospitals' chemical dependency programs should be maintained and upgraded by contracting with private sources for program consultation and evaluation. Staff training and other improvement activities should be undertaken when necessary.

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3. The original draft role statement prepared by the Chemical Dependency Division is included in Appendix F. Appendix G of this report includes a letter received from Dr. Robert M. Morse In which he discusses additional areas of need.

- D. The state hospitals' chemical dependency programs should not act unilaterally in planning and executing services, but should work in concert with related area mental health board(s), and county welfare departments in assessing client needs and developing the resources necessary to meet those needs.
- E. A continuum of care for the treatment of chemical dependency should be available and accessible to all persons needing the service in a receiving district. Services for the chronic chemically dependent person must be emphasized.
- F. All persons who need chemical dependency services have the right to treatment. Funding for chemical dependency services should follow the individual. A suggested funding procedure would be to establish actual costs for the chemically dependent client at the state hospital (minus any reimbursable income), and use this "cost formula" to determine the amount of money which could follow the client into community facilities.

## APPENDIX A

Mental Retardation Division

(PROPOSED)

10/16/78

ROLE AND FUNCTION POLICY FOR STATE OPERATED RESIDENTIAL FACILITIES  
FOR MENTALLY RETARDED PERSONS IN MINNESOTA

I. Purpose:

- A. To place state operated residential facilities in perspective with the broader Comprehensive Service System for Mentally Retarded and otherwise Developmentally Disabled.
- B. To identify the population that will be served in the state residential facilities.
- C. To delineate the role and function of state operated residential facilities as supportive to Minnesota's Comprehensive Service System for Mentally Retarded and otherwise Developmentally Disabled.
- D. To specify state facility staff responsibilities to local planning groups and other service providers in the evaluation, treatment and prevention of mental and physical deterioration that may lead to institutionalization.

II. Population To Be Served:

- A. Severely and profoundly retarded persons who have other physical or sensory disabilities that require combinations of specialized services not available in local community residential and support services.

Exclusions: 1) mildly or moderately retarded persons, and

- 2) severely or profoundly retarded persons who do not have physical or sensory disabilities.

- B. Persons whose physical or behavioral condition precludes placement in a community nursing facility.



- C. Severe behavior disorders of any retarded person who cannot be treated in community facilities. This includes retarded persons whose behavior disorders require treatment procedures which may establish conflict between the clients right to treatment and other constitutional rights. These clients will be treated within the state hospital system.
1. Treatment procedures in this category may include the moderate and intensive levels of aversive and deprivation procedures (as defined in proposed DPW Rule 39, January 1577, or its successor), and intrusive medical procedures and controls.
  2. Populations of clients include mentally retarded persons:
    - a) with destructive behavior to property, or posing severe risks to the neighborhood;
    - b) who are dangerous to themselves or others;
    - c) persons with psychotic behaviors needing intensive and/or medication controls;
    - d) who are chemically dependent.
  3. Each state facility shall develop its own capability or ensure through cooperative planning that a specialized unit in another state facility will take appropriate referrals.
- D. Persons needing and requesting temporary care through referral from the local social service agency, for which court ordered placement is not required. Services shall include:
1. Crisis care where immediate action is necessary. Admission procedures are to be established in each state facility to prevent delay in handling such emergencies.
  2. Parental relief for vacations and family emergencies when other local facility options are not available near the home community. M.S. 252A.11, as amended in 1977, permits temporary care for a specific period of time not to exceed 90 days in any calendar year.
  3. Short-term intensive training and treatment when community alternatives are not available or have failed. Specific criteria should be developed with local community staff. This may include the provision of behavior therapy as a resource for residents of local facilities when it is determined desirable to remove the resident from the current living situation.
  4. Back-up service to local residential facilities in the event of natural disaster, strike or closure. To be provided until appropriate placement can be made by the responsible county agencies and DPW's Central Office.

5. Diagnostic and evaluation services in a controlled environmental setting not appropriately available through community mental health or residential services. This is to be done on basis of request from the LSSA in order to assist in determining an appropriate service plan and placement.

E. Court ordered placement of persons under provisions of the Minnesota Hospitalization and Commitment Act.

### III. Admission, Transfer and Discharge:

- A. Admission - Admissions may be made only of these clients referred to the local social service agency in accordance with DPW Rule 185. The state facility staff may not refuse an appropriate referral (including those under emergency conditions) unless staff assist the referring LSSA until an appropriate special alternative is found. An appropriate alternative is considered to be a local community resource or another state facility that has a specialized program for that particular type of presenting problem.
- B. Transfer - The state facility staff may not transfer residents to another state facility or local community facility without the involvement and approval of the responsible local social service agency. Questionable situations shall be referred to DPW.
- C. Discharge - The state facility staff shall inform the local social service agency when a resident is determined ready for community placement, and shall assist the LSSA in developing a placement plan. Undue delay in placement shall be reported to DPW.

### IV. Role in Support of the Comprehensive Service System for Mentally Retarded in Minnesota:

- A. Mandated;
  1. To assist DPW and local units of the Comprehensive Service System in research and data collection, including assistance related to state wide services and local needs assessment. To conduct research and data collection on state facility populations as requested by DPW and make data available to local planning units.
  2. To provide aftercare planning with the LSSA as required under provisions of the Minnesota Hospitalization and Commitment Act.
  3. To participate in local mental health human service and county agency need assessment; planning and coordination of services. To ensure the opportunity of staff to be involved in state facility planning.
  4. To cooperate with mental health, human service and county agency staff in planning local placement alternatives and in making placements of state facility residents in accordance with DPW Goals and Objectives.

B. To implement this policy:

1. To develop specialized services required to carry out the provisions of this policy, which may include specialization in certain state facilities as a resource for others.
2. To conduct local studies of state facility residents who come under the provisions of this policy in order to project facility needs.

C. Legislation required to implement:

1. To cooperate and assist local mental health, human service and county agencies in providing training services for staff of local community MR facilities and support services and state facilities.
2. To cooperate and assist local mental health, human service and county agencies in program development for:
  - a) specific techniques and methodology in the care and treatment of severely and profoundly retarded;
  - b) management of behavior problems to prevent deterioration and possible referral to a state facility;
  - c) development of local community options that would encourage and allow retarded people to remain in his/her surroundings, prevent disturbance of routine, and encourage utilization of volunteers to assist in providing services;
  - d) provide training of parents and relatives of residents to assist them in providing appropriate care as requested by the LSSA.

V. Strategies:

- A. Locally operated community residential facilities and support services are expected to be sufficiently developed to care for persons who do not come under the provisions of this role and function policy for state operated facilities during the next five years. Until the local residential facilities and support services are so developed, the state residential facilities shall provide services to:
  1. eligible persons who do not come under the provisions of this policy (appropriate local community facilities are not yet available);
  2. eligible persons who do come under the provisions of this policy.
- B. State facility staff shall identify those residents for community placement who do not come under provisions of this policy. This shall include identification of those who are:

1. currently ready for placement in local residential facilities, and
2. under a training program to prepare then for placement in local facilities.

Such information shall be kept up to date and made available to DPW and the appropriate community mental health, human service and county welfare agencies for placement planning and development of services. Placements are to be made as services become available.

- C. After local residential and support services are sufficiently developed to care for all persons who do not come under the provisions of the role and function policy for state facilities, staff will be responsible for carrying out the provisions of this policy only.
- D. The Department of Public Welfare will support local county mental health and human service agencies if they opt to develop local service alternatives to persons who come under the provisions of this role and function policy, providing such development does not detract from the development of services to persons not coming under this policy.

HS/gma

## APPENDIX B

TO: Marie Gomez, Staff Person  
Residential Care Study Committee

FROM: Robin Reich, Committee Member

RE: Recommendations Pertaining to Role and  
Function of State Hospitals

DATE: October 3, 1976

*Robin Reich*

As I understand the charge to the Study Committee at the September 26th meeting, it was to return to the next meeting with suggested policies pertaining to the role and function of the State Hospital. As a committee member, I find this an extremely difficult task to perform.

There are certain realities that must be reckoned with when dealing with this task. From my point of view, they are as follows:

1. State Hospitals exist and serve a purpose. Whether that purpose is primarily focused on serving the social, vocational, and economic needs of the staff, the State and the Community, or whether it focuses primarily on the human and developmental needs of the client population is not a resolvable issue. Clever manipulation of socio-economic data could prove that state hospitals exist to serve non-client needs; however, no data exists to prove that they do not also serve the needs of the client population whom they presently house.

2. Community-based continuum of services exist, in varying degrees, for all three disabilities. These also serve a purpose. Again, whether that purpose is primarily focused on the needs of the staff and community or on the human and developmental needs of the client is not a resolvable issue. The Community-based continuum's social, vocational and economic impact on a community could be measured as could its impact on clients. To date, within the State of Minnesota, I know of no data that has been developed to measure either type of impact.

3. The conclusion that must be drawn from #1, 2 above is that it is presently not possible to categorically declare community-based placement is any better or any worse than hospital-based placement.

A. It is possible, on an individual client basis, to determine which type of placement would be most appropriate, if and only if there is complete knowledge on the part of the referring agent about the likely programmatic impact of each type of placement on meeting individual client needs. This type of knowledge presupposes the existence of program evaluation systems for each type of placement. To my knowledge, such systems are not presently in operation.

5. There are funding limitations across all three disabilities. Precisely what these limitations are has not really been well defined.

6. There are very real barriers to development of community-based services in certain geographical areas. Many of these barriers relate to the economic and social makeup of the areas, and perhaps are not within any agency's scope of control.

7. There is an assumption made that Community-Based Placement, at least in Mental Retardation, is less costly than institution placement. As the system is presently set up, I believe this is a false assumption, particularly when focus of Community-Based development is the severely and profoundly retarded population. Additional cost figures presented as evidence to substantiate this assumption are often incomplete and misrepresentative.

6. There is an assumption made that local counties tend to place in state hospitals rather than in community-based facilities. My experience in a large urban county in Minnesota has proven otherwise. Granted, this experience has been only in mental retardation; however, please note that there has not been a "commitment" for mental retardation in this particular county for the last six years.

9. There is an assumption that talent and manpower exist in the community to develop and implement community-based programs to meet the needs of mentally retarded people who are currently residing in state hospitals. Indeed they might, but due to the current system or lack thereof for local control over the development of certain segments of the continuum, local needs many times are not met.

10. Due to the different sources of funding, hence different systems of funding that are used to develop a community-based continuum, concurrent development of needed services for different segments of the continuum is often impossible.

To attempt to develop suggested policies for role and function of the State Hospital, and realizing that the above realities also exist is at best a huge task, and perhaps not very useful in the final analysis. Therefore, as a committee member, I am suggesting that, rather than developing recommendations on policies, there are concepts that should be analyzed and developed before actual policies are made. These concepts can be categorized into three areas of systems: Management Systems, Program Systems, and Access Systems.

The following outlines concepts under each system which I believe are vital to the "workability" of any policy addressing the role and function of the State Hospital.

Please note that although I am a temporary employee of Ramsey County, this material does not necessarily reflect the thinking of Ramsey County.

Management Systems refer to those activities within a service system which are necessary to plan, develop, organize, direct, control, evaluate and justify the scope and focus of the present and potential continuum of service.

1. Investigation should be done regarding developing criteria and setting priorities for "target group" planning. The main focus of this activity would be the development of a logical service system plan to meet the needs of groups of persons that are not currently being served in the community. Inherent in this activity is also the development of contingency plans which would outline reasons why certain target groups may not currently be appropriate for community placement, but may become so in the future if certain events happen.

2. Investigation should be done and agreement reached regarding who has the primary responsibility for fiscal and programmatic aspects of development of a community-based continuum of service. This includes addressing, in a comprehensive fashion, all of the current barriers (economic, social, etc.) to the development of such a continuum.

3. Comprehensive program evaluation must be developed for the full scope of both state hospital and community-based programs. The ultimate result of this type of evaluation would be measurement of programmatic impact on meeting the needs of the participants within each system. If such evaluation methodology were to be developed, it may then be possible to say that under certain circumstances one system is better than the other at meeting the needs of a given client population.

4. Consistent reporting methods on client demographics and programmatic outcomes should be developed and used by all publicly funded agencies and services. Concurrent with this activity should be the development of methodologies for updating of client information on a regular basis.

5. A system of service monitoring should be developed to insure that at a minimum, needed services exist and at a maximum, they are quality services.

6. Methodologies should be developed which would allow measurement of client flow.

7. Methodologies to insure administrative and professional accountability throughout the service system should be developed.

6. The role and responsibility of agencies providing such services as Follow Along, Family Support Services and Service Delivery coordination should be clarified.

9. The concept of increased local control over the development of needed community services should be addressed. In many instances, local planning agencies have all planning responsibility but questionable authority to insure implementation of plans.

10. Investigation should be done regarding the impact community service development is having on "The Community". The main focus of this activity should be the development of a rational and equitable state-wide planning system, based on the economic and social characteristics of a given community.



Program Systems refer to those activities within individual service categories that specifically address the program providing the service.

1. Standards should be developed which would allow measurement of cost benefit and cost effectiveness of both Community-based and State Hospital-based programs.

2. Any funding base which is currently or may potentially be use: to develop community-based services should be checked to insure maximization. of federal, state and local sources of revenue.

3. Methodologies should be developed to insure that equitable incentives exist to counties for placement in settings that meet a person's needs, not in the least expensive setting.

4. Emphasis in ell program systems, whether hospital-based or community-based, should be on meeting the needs of clients. In the case of existing community programs, further emphasis should be placed on the prevention of institutionalization. This concept includes the development of expansion of program systems for persons who, without certain support programs, may become state hospital patients.

5. Methodologies should be developed to insure conceptual programming between and among disability groups. This would include the feasibility of developing or using existing services for the "cross disability person".

6. When a person is participating in two different types of programming, a method must be developed to assure consistency in program plans. Further, a monitoring system must be developed to check the consistency. Consistency in individual program planning applies both to hospital and community-based settings.

7. Consideration should be given to the possibility of expanding programs within private and governmental human service systems which do not traditionally serve certain disabilities. This effort may reduce unnecessary duplication of specialized services while at the same time expanding the scope of certain funding, bases.

8. Methodology must be developed to reduce the planning and development discrepancies between and among segments of the service continuum.

9. Programs should be developed (and perhaps mandated) in under served geographical areas. However, this effort should not be carried out until there is a demonstration of need and an investigation into utilization patterns of existing programs that may meet needs. This includes all existing state hospital programs and community-based programs.

10. When policies are developed that influence program development, methodologies should be developed to measure the impact of those policies on program development.

Access Systems refer to activities by which a person gets into and out of any program within a service system.

1. Within the local social service areas, designated client access points should be developed to insure appropriate referral to all programs within the service system. These methods should include both community-based and hospital-based programs.

2. Investigation is needed regarding the methodology used to refer clients to specific programs.

3. Similarly, methods should be investigated as to how a client's initial program needs are determined.

4. In the case where progression through a service continuum is a measurement of a client's improvement it) functioning, criteria should be developed to determine if potential exists for such progression or, if a criteria other than progression would be more appropriate to meet needs.

5. If it does not appear that a client has the potential for progression through the service continuum, funding sources should view the different criteria as a viable outcome for program participation.

6. When a client does move through the service continuum, a system should be developed to allow easy access back to a former program if necessary.

No doubt there are many other issues that should be considered before policies are developed on role and functions of state hospitals. However, I believe the above are some of the most important if any policy is to be client-appropriate and program-appropriate.

RP.:pg

cc: Cyndy Whiteford, Director - Office of Policy Analysis and Planning  
Harvey Caldwell, Assistant Commissioner - Mental Health Bureau  
Ardo Wrobel, Director - Mental Retardation Division, Minnesota Department of Public Welfare

## APPENDIX C

Edward J. Dirkswager, Jr.  
Commissioner  
Dept. of Public Welfare  
Centennial Bldg.  
St. Paul, MN 55155

Dear Commissioner Dirkswager:

November 24, 1978



This letter is written as a summary by the undersigned, relating to the work of the Department of Public Welfare's Residential Care Study Advisory Council, appointed by Commissioner's letter on July 17, 1978. We, the undersigned, were appointed members of the Council with a special interest in mental retardation services.

We understand that the charge to the Council is to assist the Department in defining the future role of state hospitals. Representatives of three disability groups - mental retardation, mental illness, and chemical dependency - struggled with this charge through a series of eleven weekly meetings, each about three hours in length. As Council representatives for the mentally retarded, it is our opinion that, after thirty-three hours of meetings, the Council did not fulfill its charge. However, there were developed through Council deliberations some unique understandings concerning mental retardation services in Minnesota, and the state hospitals. We wish to share with you our view of these understandings.

Mental retardation services in Minnesota are unique, in that every known type of service to mentally retarded people is presently being provided in the community. This point is of paramount importance, for it sets mental retardation services apart from services for the mentally ill and chemically dependent, and it is the cornerstone upon which our argument is built.

One of the implications of this fact is that the state hospitals have not demonstrated exclusive superiority in providing any kind of service. This is not to say that community services have demonstrated such superiority; we do not want to engage in this kind of argumentation. For purposes of this discussion, we merely state that neither hospital nor community has demonstrated an exclusive superiority.

If state hospitals have not demonstrated a programmatic superiority, how is the role of the state hospitals to be determined?

Our argument is that the role of the state hospitals in serving mentally retarded persons is determined by factors which are largely ignored in the "Draft Report of the Advisory Council's Recommendations," but which - if addressed by the Department of Public Welfare - could lead to quality, efficiency, and effectiveness in service delivery. These factors are social, economic, political, and administrative.

Social factors are illustrated by the traditional role of the institution as an instrument of social control. It used to be that the community wished to rid itself of deviant types, and the state hospital was the instrument by which this was accomplished. We speak in the past-tense, because we believe that communities have come to accept the mentally retarded. (Council discussions, on the other hand, lead us to believe that this social dynamic is still at work in other disabilities, witness the over-representation of non-white, chemically dependent persons in state hospital programs).

Economic factors are those which cause the community to regard state hospital programs as local industry, and the employee to regard the hospital as a job. Another economic factor is that the cost of state hospital services is less to using counties than placement in community facilities. Using counties pay proportionately less of the cost of service in state hospitals than in community facilities.

Political factors are the legislative policies that serve to protect state hospitals as local industry, to preserve civil service jobs, and to pay a larger share of the counties' costs for residents in state hospitals.

Administrative factors are summarized in DPW Rule 185 governing the planning and provision of services to all individuals who are mentally retarded. A major component for the administration of this program by DPW is the local social service agency which has responsibility for development of an individual service plan. This plan must include:

"Provision for implementation of the individual service plan and arrangement for appropriate services."

"Provision for ensuring the delivery of services as provided in the individual service plan."

In other words, the services that an individual needs are prescribed through a process of assessment and individual program planning. And it is the aggregate of these individual

Page 3  
Nov. 24, 1978  
Edward J. Dirkswager


decisions that should ultimately determine the future role of state hospitals.

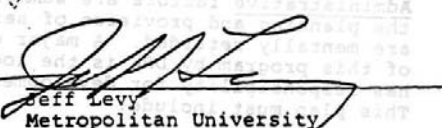
Unfortunately, this is not the case. Indeed, the future role of state hospitals may be determined largely by factors that have nothing to do with the needs of individuals: the social economic, and political factors described above. Our principal argument before the Council is that the Department must address these "non-programmatic" factors if the programmatic mechanism established by the Department (Rule 185) is going to work. The Department must:

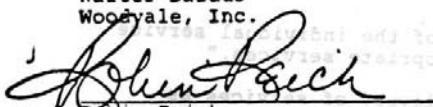
- ° Eliminate the lower cost to the counties of the state hospitals;
- ° Make it possible for state hospital employees to transit to non-public employment without major loss of wages and benefits;
- ° Clearly bring the state hospitals into the licensing, cost control, and needs assessment systems that govern the non-public sector;
- ° Engage in an active campaign to persuade communities to provide the services needed by disabled persons.

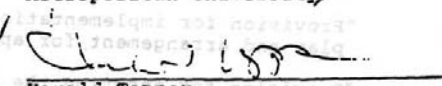
If the Department were to take these actions, the future role of state hospitals could be determined by the needs of the individuals they serve rather than by non-programmatic factors. And - make no mistake - we believe that these non-programmatic factors are so powerful that - unless they are neutralized - the Department of Public Welfare will be unable to influence the role and function of state hospitals.

As Council members representing the interests of mentally retarded persons, we would be pleased to participate with you as these issues are addressed.

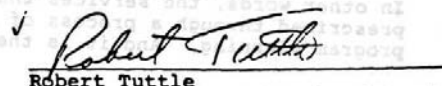
✓   
Walter Baldus  
Woodvale, Inc.

✓   
Jeff Levy  
Metropolitan University

✓   
Robin Reich  
Minneapolis

✓   
Harold Tapper  
Association of Residences for the  
Retarded in Minnesota

cc: Harvey Caldwell  
Ardo Wrobel

✓   
Robert Tuttle  
Minnesota Association for Retarded  
Citizens.

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## APPENDIX D

## MENTAL HEALTH ADVOCATES COALITION

### RECOMMENDATIONS TO RESIDENTIAL CARE STUDY: D.P.W.

I. It is our position that no state hospitals be closed without provision for the funding of a continuum of community based services. This means there will be a commitment by the state legislature to provide treatment programs for the mentally disabled in the community where they live, i.e., the Hastings State Hospital closure indicated that the state abdicated their responsibility to Hastings' former patients by not transferring that money into the community and not implementing or funding the East Metro Plan.

II. Presently the state hospitals should be a meaningful component in the continuum of care. That role may vary according to regional needs. Regional planning seminars should be established to determine the needs of specific areas based on their unique demographic and geographic situations, as well as the availability of other mental health resources in that area. These planning seminars should determine how the state hospital, community mental health centers, and county welfare departments can work together to establish a viable continuum. A machinery needs to be developed in order to assess, coordinate, and plan services in different regions.

III. Pilot projects such as those implemented in the Denver and Madison models could be implemented in some areas where aftercare or crisis intervention services are lacking. In this way state hospital monies could be used to provide community services. In Denver, Fort Logan State Hospital money and staff were used to fund their program. In Madison, state hospital employees were retrained to work in the P.A.C.T. Project. All pilot projects should be evaluated and coordinated with the present system.

IV. Alternatives to hospitalization such as crisis intervention centers, safe houses, and foster home placement should be established to reduce unnecessary admissions. In cases where a client is eligible for hospitalization or where hospitalization is necessary for purposes of monitoring drugs or receiving medical care, then the hospital staff should be involved with that person prior to admission, at the crisis situation that calls for intervention. If a social issue is the cause of admission then that issue should be dealt with in the hospital and at the time of discharge.

V. The present state hospitals should try to achieve:

- A. A more humane environment with the patients having more involvement in their own treatment goals.
- B. A volunteer program which would encourage patients to become better acquainted with their own community, and would involve the community more in their treatment.
- C. Programs for families of patients, with involvement both at the time of admission and the time of discharge.
- D. The state hospitals must be involved with a patient's after care program and work directly with county welfare departments and community mental health centers.
- E. State hospitals must provide training in living, and vocational training if necessary.
- F. Because the hospital is a controlled environment, medical and nutritional attention should be mandatory.



## APPENDIX E

## ROLE STATEMENT - MHCs MH Program

### Philosophy of Community Mental Health

The main goal of mental health services in the State of Minnesota is to provide for the development and maintenance of individual and family strengths. Mental health services need to be provided in a manner which enhances growth and discourages dependency on the system. The provision of services need to be in a manner which respects the individual and his/her dignity as a person with the right to privacy and self-determination.

Treatment services for individuals and families should be provided in a manner which causes the least disruption in daily living patterns and in a manner which encourages individuals and families to receive help while maintaining family, job, and community relationships and responsibilities. Where disruptions do occur, services need to assist in reestablishing the daily living relationships and roles. A broad spectrum of services are needed which provide a continuum of care going from educational/informational services to extensive, intensive care services. In order for the continuum of care services to be relevant to individuals in distress, the services need to be easily accessible, individualized, and flexible to meet the specialized needs of the individual and his/her family. Services and programs need to be designed to enable early identification and intervention to minimize the human suffering involved in mental illness.

Mental health programming and services need to be responsive to geography, population density, and other local factors. The local area mental health board or human service board is that local body which is responsible for the planning, designing, coordinating, and implementing programs and services for mentally ill individuals and their families in the local area (catchments area). While the mental health board/human service board may not directly provide all services for the mentally ill, the local board has the "see to it" responsibility that a continuum of care services are available to persons in the catchments area. The catchments area is that geographic area of the local governmental units which officially provide financial support, and the area over which the local mental health board/human service board has program responsibility. The service program must have a system of ongoing review and evaluation of services provided, as well as an ongoing system of assessing the service needs of those within the catchments area. This ongoing review needs to include a system of citizen input and overview. The evaluation review needs to include methods of cost effectiveness of the services that are provided and the establishment of priorities based on outcomes, costs, and local needs.

### Description of Community Mental Health Continuum of Care

#### Introduction

The following descriptions and categories are taken directly from Policy Statement #1 of the Minnesota Association of Mental Health Programs, and from a paper written by the Policy Committee of this Association. Policy Statement #1 clearly delineates the role of the CMHP, as spelled out in

\* The purpose is to jointly plan, develop satisfactory policies, and to assure the development of a comprehensive continuum of mental health care treatment throughout the geographic area, with respect to the responsibility each agency will have.

a. To develop and maintain a standing policy of effective working relationships with mental health centers, county welfare departments, local hospitals, physicians, nursing homes, law enforcement, and vocational rehabilitation offices.

b. To establish contact with other agencies, such as schools, courses, employers, churches, charities, workshops, group homes as required with respect to particular patients.

10. To assure the availability of necessary psychiatric care for any resident of the receiving area, irrespective of insurance or other personal financial resources.

11. To devise educational and collaborative contact with families of mentally ill hospitalized persons, particularly where it is clear that the onset or aggravation of the patient's illness is related to family behavior or where family support in a difficult post-hospital situation may be needed to avoid relapse. Definitive family therapy may be recommended by hospital staff, but may not necessarily be provided by them. Rather, such need may be referred to a community resource.

## I. Description of Program and Services in the Continuum of Care

Parts of the continuum are provided and funded through state funding sources and also private sources, but those parts of the continuum which the state mandates would require state funding. State funding may be more or less extensive depending upon the area served.

### A. Family and Individual Support Services

#### 1. Informal, Nonprofessional Support Systems (Family, friends, employers, neighbors)

These are people who provide support, guidance and direction which is often sufficient to help the individual manage his or her problem, short of any kind of organized intervention. These groups should be seen as potential resources by the professional community and programs designed to maximize their effectiveness.

#### 2. Formal, Nonprofessional Support System (A.A.. Weight Watchers, Emotions Anonymous)

This would include primary peer support groups which are designed to help the individual and/or family deal more successfully with a particular problem without formal professional intervention. Although it is not the community mental health center's role to establish these types of support system, the staff should be available to provide guidance and recognition of their role in the continuum.

#### 3. Support Systems Which Alloy Continuation in the Family Home - Paraprofessional

Respite Care - These programs are designed to maintain the individual in the home by providing relief services for family which allow them to be relieved of the responsibility of care of the retarded or mentally ill individual. People providing this service would be trained to work with individuals having a specific kind of disability. The precise of this program is that it is most often preferable to keep the retarded or mentally ill person with their family. This is more often possible if the family can have the assurance that they will have periodic relief from the burden of care and that their family member will receive qualified care during that period.

#### 4. Other Activities

Educational programs for specific interest groups, such as those designed to: 1) assist families in understanding and improving their parenting roles; 2) increasing the understanding of the psycho-physiological problems associated with various disabilities.

educational programs should also be designed to help the general public understand and be more receptive to the presence of disabled people in family groups and neighborhood communities.

- 2B. "Collaborative and Cooperative Services with public health and other groups for purposes of prevention of mental illness, mental retardation, alcoholism and other psychiatric disabilities."

Chapter 245.6, Minnesota Statutes, gives the Commissioner of Public Welfare authority to make grants for the operation of local mental health programs.

1. Community Mental Health Board Responsibility

a. Requires the Community Mental Health Board to serve as the coordinating and convening agency of community caretakers for the development of preventative programs for mental illness, retardation, addiction and other psychiatric disabilities.

b. Requires the Community Mental Health Board to develop programs for prevention of mental illness, retardation, addiction and other psychiatric disabilities.

1. Primary prevention programs addressed to adverse influences of society. Individuals as well as groups are the focus of these programs designed for early detection and intervention, such as crises intervention, early case finding.

2. Tertiary prevention programs for follow-up and rehabilitation of the above disability groups.

2. Planning and Coordination

The area mental health authority will have overall responsibility for the planning, coordination and service development.

a. Needs Assessment

(A formal and in-depth needs assessment should be completed once every five years.) The area plan would be based on this assessment utilizing information gathered by the mental health authority, as well as other area agencies, such as health planning agencies and regional development commissions. It should include a current catalog of resources available to meet needs, as well as a plan to develop services to meet unmet needs.

b. Coordination of Services  
The hallmark of a comprehensive community mental health service system highlights coordination of programs and services with all parts of the helping system. This means collaboration and

- b. Requires Community Mental Health Board to provide varied therapy programs, such as crises intervention services, emergency services, ongoing treatment programs, etc.
- c. Requires Community Mental Health Board to provide diagnostic service to all area residents and other community caretakers.

2. Diagnosis, Evaluation and Disposition

This is a process whereby professionals and para-professionals, by the use of various techniques and instruments, identify problems, their severity and alternative method of care and treatment.

3. Precommitment Examination

This is a specialized service designed to assess the nature and extent of the person's disability, for the purpose of determining what, if any, intervention is necessary and further possible available alternatives to hospitalization. Such examination requires close coordination between the central health center and the county welfare department.

4. Treatment Programs

Various treatment programs designed to meet specialized needs of individuals, families or groups using a variety of treatment modalities, such as individual, group, family, play, activities, therapies, marriage, alcohol, chemotherapy, and other counseling services. Therapy programs are designed to meet individual patient needs with specific treatment goals which must take into consideration the person's current situation and motivation to change, as well as skills of staff and available knowledge. Effective treatment programs will utilize all community treatment resources as a part of the treatment effort.

C. Partial Care

Those programs designed for individuals who do not need 24-hour care.

1. Day Treatment

Programs designed for individuals who may need more intensive intervention and support than provided in the usual outpatient services. Day care hours are usually 8:00 a.m. to 5:00 p.m. and would assist individuals in developing socialization, recreational and job skills.

2. Night Care

Program designed to provide partial care for individuals who can function during the daytime with family, friends, etc., but who need the support of night care to assist in their returning to the community.

### 3. Specialized Partial Care

A program that is necessary for a patient who cannot handle the stress of living outside a residential program, especially, but not exclusive of weekends when organized activities, job, etc. are not available and fail to provide the structure and protection needed by the patient.

- \*E. "Rehabilitative Services for patients suffering from mental or emotional disorders, mental retardation, alcoholism, and other psychiatric conditions, particularly those who have received prior treatment in an inpatient facility."

#### 1. Area Board Responsibility:

- a. Requires Community Mental Health Board to provide direct service program for post-hospital patients.
- b. Requires Community Mental Health Board to develop treatment services beyond those described above to meet the specific needs of persons with more chronic or deep-rooted disturbances.

#### 2. Post-Hospital Program

This will include specialized programs and services to meet the particular needs of patients returning to their families and communities following inpatient hospital care. These programs should be specifically designed to support the patient's return to their community and would vary in content from patient to patient.

### I. Community Residential Services

These services provide varying levels and types of residential care aimed at meeting various patient needs dependent primarily on severity and chronicity of a patient's problems.

#### 1. Supportive Living - Minimal Supervision

Programs that are designed to provide a supportive group living situation with little or no formal program activities involved with the residential service. This service is expected to encourage greater levels of independence by having the patient assume responsibility for purchasing and preparation of food, caring for the facility in which they live, etc. Supervision in the home would most often be by peer group or former residents. This program would serve all three disability groups and could be provided in one facility or in several. It would be seen as a short-term group activity, not to exceed six months, and most often averaging two to three months.

Therapeutic needs of people participating in this program would be provided on an outpatient basis through the mental health center or others and may often include sheltered work on regular employment.

2. Croup Hones

This setting would provide both the supportive group situation and a formalized system of supervision. It would be designed for the patient who may need a longer term structured living situation. For some, this may be a transitional stage toward more individual living, while for others, such as the mentally retarded, this may be a permanent living arrangement.

3. Crisis Facilities

These facilities are designed to provide brief crisis intervention programs. They would include such facilities as receiving and referral centers (detox) or crisis homes for the mentally ill, battered women, and others. It would provide for diagnostic, evaluation and intensive therapeutic intervention, sometimes used as an alternative to hospitalization (Denver Model).

4. Short-Tent Intensive Treatment - Hospital and Nonhospital-Based

This service is designed to meet the needs of patients requiring the protected setting of a hospital or nonhospital setting which provides a high level of professional involvement with patients who are in an acute and/or severe state and who can benefit from a brief or short-term intervention. The decision to use the hospital-based facility would depend primarily on the degree of psycho-physiological impairment and whether hospital-based medical procedures are indicated.

5. Long-Term Residential Programs

This is treatment aimed at patients who require long-term intensive care beyond that provided in short-term community care programs. For example, this may be for patients who require more structured or more specialized services, such as the alcoholic patient, some specialized services for the retarded who have multiple physical problems in addition to retardation, specialized services for the mentally ill, including services for the dangerously mentally ill and special long-term programs for adolescents. The nature of the specialized programs in state facilities should vary from area to area based on the needs of the area and its ability to meet those needs.

6. Domicialry Care

This program is designed for the patient whose illness is of a chronic stature and where numerous attempts at remediation have

- 5  
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failed. The program would primarily be aimed at providing a humane level of care and supervision, but not designed to achieve any basic changes in the individual's problem structure or level of functioning. It would include provisions for periodic reviews to ensure that new techniques or changes in the individual would not indicate the possibility of remediation.

**J. Provision for Program Review and Evaluation**

A responsible service program must provide a system of ongoing review and evaluation, including gatherings of the usual statistics and outcome information, as well as a systematic system of citizen input and overview. It must also include methods of determining cost effectiveness of various treatment modalities and services and establishing priorities based, in part, on outcome and cost, but primarily on local need. These statistics and outcome information should be reported regularly to the Legislature, State Welfare Department and local funding bodies.

**K. Research**

GT/blf

## ROLE OF THE MINNESOTA STATE HOSPITALS FOR THE MENTALLY ILL

### Appropriate Roles

The appropriate roles are many, but finite and are not exclusive to hospital:

1. To provide a diagnostic and evaluative service for those believed to be mentally ill; this includes the self-referred and those recommended by other agencies or sent by courts.
2. To provide a comprehensive range of treatments for all mentally ill who require continuous, intensive, specialized or segregated care on a residential basis including:

emergency	) either voluntary or involuntary
short-term (one to 90 days)	) according to MHCA
long-term (three months upward)	)
3. To provide detention and treatment for those mentally ill who are judged to be a hazard to themselves or others and, therefore, in need of segregation, protection and where required, involuntary therapies. This includes the confused, the self-injurious and the assaultive.
4. To provide in one (or more) hospital(s) specialized facilities for children and adolescents, for geriatric patients and for serious security risks. (As a rule, each hospital can maintain a geriatric unit. Children and security problems will require special facilities.)
5. To provide a base for partial hospitalization of those mentally ill who need only the daytime (or nighttime or weekend) services of the hospital or who need only intermittent care, which is not otherwise available in the area.
6. To provide a service for those mentally ill who have additional handicaps (chemical dependency, retardation, physical disorders) which make other forms of care ineffective or unavailable.
7. To provide a follow-up service in conjunction with local community agencies and services, particularly outpatient care of a clinical nature where no other resource exists or, in certain cases, when continuity of care by hospital staff is deemed best. All follow-up planning must be three-part joint-planning process between state hospitals, central health centers, and county welfare departments. The state hospital shall have involvement with the mental health center and county welfare department in development of the aftercare plan and in the designation of the case manager.
8. To provide outpatient consultation and treatment capability for the mentally ill as a backup for community mental health centers or local physicians, particularly in respect of former patients or potential

\* The purpose is to jointly plan, develop satisfactory policies, and to assure the development of a comprehensive continuum of mental health care/treatment throughout the geographic area, with respect to the responsibility each agency will have.

- a. To develop and maintain a standing policy of effective working relationships with mental health centers, county welfare departments, local hospitals, physicians, nursing homes, law enforcement, and vocational rehabilitation offices.
  - b. To establish contact with other agencies, such as schools, nurses, employers, churches, charities, workshops, group homes as required with respect to particular patients.
10. To assure the availability of necessary psychiatric care for any resident of the receiving area, irrespective of insurance or other personal financial resources.
11. To devise educational and collaborative contact with families of mentally ill hospitalized persons, particularly where it is clear that the onset or aggravation of the patient's illness is related to family behavior or where family support in a difficult post-hospital situation may be needed to avoid relapse. Definitive family therapy may be recommended by hospital staff, but may not necessarily be provided by them. Rather, such need may be referred to a community resource.

Addendum

Limits of Mental Illness

In order to carry out the above purposes, mental illness hospitals need to have a clear working appreciation of what mental illness covers. Despite well-known divergence of philosophies on this subject, some agreement must be reached about the differences and similarities between defined "mental illness" on the one hand and a wide range of other disabling conditions or behavior on the other, which, in themselves, do not constitute mental illness, as for example:

- alcoholism
- drug abuse
- sex offenses
- incorrigibility, recidivist
- destitution
- gross folly
- senseless or bizarre crises
- retardation
- specific learning disabilities
- runaway, truancy
- bad temper, assaultiveness
- unemployability, vagrancy

This agreement on limits should be internal, that is, among the professional staffs of the hospital, and then negotiated between the hospitals and the other agencies and facilities who may wish, at times, to define such conditions or behavior as "mental illness". The proposition that such may be products or symptoms of mental illness should be examined with care.

Where both mental illness and offending behavior coexist, the role of the state hospital will have to be carefully defined both clinically (Is the mental illness paramount? Is it the source of the behavior?) and administratively (Are prisoners to be admitted to non-Corrections mental hospitals?).

In general, why any of the complications described above are minor or do not seriously distort the purpose or operation of a psychiatric hospital, such persons may be hospitalized for their mental illness and other agencies be invited to help with the complication. Of themselves, such complications are not mental illnesses and, singly or in combination, do not justify inclusion of such persons in a mental hospital population.

There are other similar personal conditions which fall in the area of natural calamities which again may complicate mental illness or be so severe as to approximate mental illness. A few are: loneliness, grief, remorse, despair, pessimism, hatreds, fears, family conflict, unhappy marriage, no sense of purpose, no home, etc. As a rule, MI hospitals offer incidental service for such persons, that is a safe and supportive locale where spontaneous resolution can better occur and where other disabilities can be conveniently attended to be the existing network (vocational rehabilitation, etc.).

Clinical criteria, such as the American Psychiatric Association's Diagnostic and Statistical Manual (DSM II, DSM III) are appropriate guides for delineating mental illness from other disabling conditions.

Failure to adhere to some such manifestly clinical diagnostic approach of diagnosis will expose hospitals to exploitative pressures which can damage progress and demoralize staff. (Too global an approach to "community needs" (the so-called "Statue of Liberty" attitude] while long on posture is unhappily short on performance.)

While using a clinical criteria in defining the role of a hospital, there will be full use of social and other non-medical modalities in the care and treatment of the mentally ill.

#### Criteria for Inpatient Admission to MI Hospitals

To require 24-hour residential care, the disability needs to be fairly substantial. Written guidelines for admission criteria appropriate for each diagnostic category are now available ("American Psychiatric Association Model Criteria 1974"); for instance, in schizophrenia, the kind, severity, and complexity of the psychological symptoms is one factor in deciding admission. The degree of disruption at home or at work is another. The availability or not of suitable non-hospital services is a third. Failure at previous trials on other progress is a fourth. The need for close supervision of Dedication is a fifth. Similar tables for depression, adolescent adjustment reaction, senile dementia, etc., are also in use to assist admission officers and audit committees in deciding which mentally ill should be in hospital. These criteria are based on national experience and can be modified for local use.

Criteria for discharge are comparable to the above. Local needs, local availability of follow-up facilities, nursing homes or supervised living all influence decisions on discharge. Although not a proper function of the hospital, making up for deficiencies in other services may be inevitable as the only humane course under the circumstances. Local corrective action should be sought by interaction between hospital and community agencies -see #9 in Appropriate Homes section.

#### Role in Relation to Other Psychiatric Hospitals

1. Where no other hospitals, general or psychiatric, offer full inpatient care for the mentally ill, the state hospitals will cater to the whole area.
2. Where other hospitals are so offering, the state hospitals will offer comparable services and, in addition, insure availability without a financial or time limitation.

#### Note:

It should be clearly understood that the state hospitals shall be of such quality that patients may well choose to have care there over an alternative

hospital. The state hospital's role is NOT one of picking up or collecting only the patients unpopular with or rejected by other facilities.

The proper balance between state and nonstate psychiatric services should be sought by constant liaison with all community agencies to ensure that no area of need is left unattended and, conversely, that areas of responsibility of other agencies are not passed to the state hospital by default.

CT/bla

## APPENDIX F

DRAFT  
April, 1978

#### ROLE OF CHEMICAL DEPENDENCY UNITS IN MINNESOTA STATE HOSPITALS

The Chemical Dependency Units of the Minnesota State Hospitals serve the citizens of the state, functioning as parts of the total of state supported services within hospital campuses and within the chemical dependency treatment, system. Chemical Dependency Units offer a variety of services, based upon the needs of the catchments area in which the State Hospital is located. A definition and description of these services, and a chart explaining which services are offered in each State Hospital is attached.

Inherent in the concept of a system of state supported services' for the chemically dependent is a relationship between referring agencies, County Social Service Departments, Mental Health Centers and other treatment and aftercare agencies that insures maximum delivery of services to clients. State services should be integrated and coordinated with Area Mental Health/Human Service Boards which assess and determine client needs as well as plan for chemical dependency services to meet those needs. State Hospital Chemical Dependency Units should not act unilaterally in these matters; but should work in concert with related Area Board(s) in the assessing of client needs and planning of services.

The State Hospital Chemical Dependency Units participate in the Department of Public Welfare research and data collection process. This record-keeping provides extensive data for research and for the evaluation of the quality of care provided. The State Hospitals



should provide this information to related Area Board(s) to assist in the assessment of and planning for chemical dependency services within specific catchments areas.

The Chemical Dependency Units in State Hospitals should provide the facilities and services necessary to meet local, state and federal requirements and to ensure maximum patient care at minimize cost. Chemical Dependency Units should maintain the highest standards in the delivery of services to ensure that these services continue to be among the best available in both private and public sectors.

No person in need of residential care should be refused admittance due to lack of funds to pay for treatment services.

Chemical Dependency Units have special legal obligations to provide services for clients referred or remanded by the criminal justice system, for clients who are mentally ill or mentally retarded as well as chemically dependent, and for clients who are received under Court Hold Orders, Physicians Emergency Admissions or Peace Officer's Emergency Admissions.

Chemical Dependency Units are a resource of professional expertise used by the entire community.

# DRAFT

This addendum to the role is to clarify what hospitals are now doing, certain things, in the continuum of care. There are also needs which are being evaluated at this time, i.e. MI - CD Unit, outpatient, and evaluation.

## ADDENDUM

	Decon on Emerg.	Out Patient	1. Primary	2. Extended	Extended Comorbidity Type	3. After Care	4. Adolescent	5. Women's (not mixed) (model)	Native Am.	6. Family	7. Trauma Prog
Albany	X		X	X		X		SPECIAL GROUP	X	X	
Albany	X		X			X	X	X	X	X	X
Albany Falls	X		X	X	X	X	X	PRE-AD, NURSING GROUP	X	X	
Albany Lake	X		X	X		X					
Albany Peter		Limited	X	X		X				X	
Albany	X		X	X	X	X	ADULT	SPECIAL GROUP		X	
Albany			X			X					

1. In-Patient Primary Treatment: The in-patient primary treatment model was designed to provide intensive short-term treatment for chemically dependent persons who require an interruption in normal social activities for treatment purposes but who also indicate a clear potential for return to the community upon completion of treatment.

EXAMPLE: Primary treatment generally consists of 30-45 days of in-patient treatment during which several methods are used to help the individual work through four basic areas of the illness - denial of the problem, compliance, acceptance of the disease and powerlessness over mood-altering chemicals, and surrender to reality of the need of help to handle life without the use of a chemical. Methods of treatment include: one-to-one counseling, family counseling, written assignments, clergy counseling, peer group concern, AA oriented programs, and contractual aftercare involvement and follow-up services.

2. In-Patient Long-Term Treatment: The in-patient long-term treatment model was designed to provide service for those clients who indicate a need for social, vocational and emotional rehabilitation in addition to treatment for chemical dependency. The rehabilitation is specifically geared to the needs of the individual client, some of whom may require longer periods of reconstruction in order to become capable of resuming responsible life within the community.

EXAMPLE: One long-term program is a program for the chemically

dependent who has been through primary treatment three or more

without substantial recovery. The program deals with the same basic areas of the illness covered in in-patient primary treatment. Average length of stay is four to six months. Additional objectives include: assistance in the areas of resocialization, job skills and job placement, accomplished through participation in Alcoholics Anonymous, hospital and workshop work adjustment training, Department of Vocational Rehabilitation, and job placement resources.

Additional long-term program is provided for the chronic recidivist chemically dependent person. The average age of residents on long-term units is 60 years old. Patients in these units generally have had numerous treatment admissions and in many cases, may have sustained brain damage affecting comprehension and insight abilities. The programs use one-to-one counseling and group therapy to help patients accept the reality that they are in need of help dealing with life without chemicals. Involvement in Alcoholics Anonymous to exposes patients to other recovering alcoholics. Regaining social skills; reclaiming self-worth, self-confidence and work skills is accomplished through this rehabilitation program.

3. Aftercare Program: Aftercare programs provide a network of resources with a continuation of low-structured services to the client to ensure total ongoing health and well being upon re-entry into the social structure.

The state hospital programs should have a clearly defined role in follow-up and aftercare of patients discharged from state institutions. Policy delineation is required to clearly define

the role of related services and community mental health centers in this area.

This approach toward coordinated aftercare services provide the best level of service possible within the resources available and would increase availability of resources through shared planning.

Aftercare Planning & Services should focus on the normal reactions of patients experiencing difficulties with the same problems after treatment as they did before and during treatment. Aftercare should emphasize the continued building of self-acceptance, demonstration of change and maintenance of freedom.

4. In-Patient Adolescent Treatment; The in-patient adolescent treatment models were designed to facilitate the complex reconstruction of chemically dependent youth and the problems peculiar to this age level. More intensive work with both family and educational systems is required in order to address the total rehabilitation of the chemically dependent adolescent because of the social dynamics of the youth within the community. EXAMPLE: A program for the in-patient adolescents between the ages of 12 and 18, is based on the philosophy that youth live in three different systems of life - family, school, and society. Through close involvement with the families and schools, communication problems, personal problems, behavioral problems, and learning disabilities are approached to develop strengths to handle life's problems without chemicals. The unit is set up on including staff as part, of the peer group. Length of stay is

determined by individual needs, but six months or more may be necessary in some cases. A frequent and important aspect of treating this age group is work with the criminal justice system.

5. The In-Patient Treatment Model for Women: The in-patient treatment model for women was designed to address the unique problems of women in general as well as the problem of chemically dependent women. Part of the treatment process is directed at evidencing and ameliorating some of the rigid societal role definitions and behavioral double standards which are often antecedent or participating causes of chemical use problems among women.

EXAMPLE: This treatment unit is designed for women, with women counselors and staff. The same methods are used as in primary treatment to help chemically dependent women recover. Unique advantages of this program are the treatment environments in which women in such areas as human sexuality, sexual abuse, incest, sexual confusion, rap, etc. Women tend to receive the necessary confrontation from a peer group of other women more readily than from the males, are more likely to approach problems realistically, and have the opportunity to work on developing healthy and supportive relationships with other women. Chemically dependent women often face overwhelming feelings of loneliness, low self-worth, and poor inner feminine image; therefore specialized treatment in an all female unit is of minimum importance.

6. In-Patient Family Treatment: The in-patient family treatment model, consistent with the growing recognition of the

of the direct relationship between chemical dependency and dysfunctional family systems, was designed to increase the potential for recovery of both the Individual in-patient client and his/her family or significant others.

Family treatment programs in the state hospital setting provides a unique service to family members who would not normally receive any treatment in programs in which the focus is on the identified patient only and not on the family members. In many areas the only other family program available is Al Anon, a self-help volunteer program.

EXAMPLE: A family program at a state hospital emphasizes 'problem recognition; the disease of chemical dependency, the family illness, and the enabler role. Self-awareness and acceptance are the expected results of the above problem recognition. Further in-patient efforts should be directed at self-acceptance and self-actualization and establishment of viable family systems.

7. Training Program: Counselor Training Programs, which train eligible individuals in knowledge, skills, and abilities necessary for performance as chemical dependency counselors, provide a valuable service to the field. Trainees may subsequently acquire positions in state hospitals treatment facilities, county welfare agencies, etc., upon completion of training.

**Curriculars Include:**

**Psychology- Evaluation**

**Alcoholics Anonymous**

**Chaplaincy**

**And**

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## APPENDIX G





Robert M. Morse, M.D.  
*Adult Psychiatry*

December 8, 1978

Harvey G. Caldwell  
Assistant Commissioner of Mental Health Bureau  
Department of Public Welfare  
State of Minnesota  
Centennial Office Building  
St. Paul, MN 55155



Dear Mr. Caldwell:

Thank you for sending me the draft report of the Advisory Council's recommendations regarding residential care. As you know, I have been an alternate member of the Council and unfortunately unable to attend the regular meetings. However, I have remained interested in the Council's work and have reviewed its recommendations.

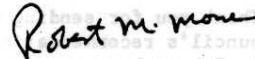
In general, I think the recommendations regarding the role of Minnesota State Hospitals for the chemically dependent patient, are well thought out and reasonable. I do have some thoughts, however, regarding Appendix E which outlines the role of chemical dependency units in the Minnesota State Hospitals. We are all aware that chemical dependency and psychiatric disorder overlap in many cases and in many treatment centers. I would think that this is particularly true among State Hospital patients and have felt for some time that an area of need and perhaps expertise to be developed particularly in State Hospital settings would be an approach to the chemically dependent "mentally ill" patient. In other words, rather than duplicate the rather good primary treatment facilities in our state by erecting similar programs in State Hospitals, perhaps we should emphasize the need for a little different approach directed toward the particular type of patient found in those institutions. At least one State Hospital has proposed such a program to my knowledge. Along the same line, I would question the need for a "primary treatment" program in each of our existing State Hospitals and wonder whether these might be centralized, again in light of the well developed system of private treatment centers and also the known shortage of staff personnel in State Hospitals.

December 8, 1978

On the other hand, I would hope the State Hospital facilities might seek to provide extended care facilities for the chemically dependent and perhaps even domiciliary care facilities, needs which are not currently being met by the private treatment centers. Finally although one can make a good case for special treatment centers for certain minority groups such as the native Americans, I do seriously question the need for specific inpatient programs for women. Certainly, in our experience and I believe most other treatment centers, women comprise a sizable proportion of the patient population and seem to respond to treatment at least as well as male patients.

A minor correction would be advisable in that I am listed under the initial page as a member of the Advisory Council simply by my title at the Mayo Clinic. I believe I was placed on the Council more from the standpoint of my membership in the State Chemical Dependency Advisory Council and this should be reflected. At any rate, I appreciate your letting me review the recommendations of the Council and make a couple of my own.

Sincerely yours,



Robert M. Morse, M. D.

RMM:mm

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